RACGP

Royal Australian College *of* General Practitioners

Healthy Profession.
Healthy Australia.

RACGP submission to the Senate Select Committee on COVID-19

Inquiry into the Australian Government's response to the COVID-19 pandemic

June 2020

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade, East Melbourne VIC 3002
Tel **1800 4RACGP** | 1800 472 247 Fax (03) 8699 0400 Email racgp@racgp.org.au
racgp.org.au ACN 000 223 807 ABN 34 000 223 807

Contents

1. Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Senate Select Committee on COVID-19's inquiry into the Australian Government's response to the COVID-19 pandemic.

The RACGP is Australia's largest professional general practice organisation, representing over 41,000 members working in or toward a career in general practice.

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist general practitioners (GPs) in their pursuit of excellence in patient and community service.

1.1. General comments on the response to the COVID-19 pandemic

The Australian Government's response to the COVID-19 pandemic has yielded positive results. Australia has performed incredibly well in comparison to other countries around the world, managing to successfully limit the spread of COVID-19 and flatten the infection curve.[1]

It should be noted that, while the focus of this inquiry is on the federal government's response to the pandemic, much of the public health policy and implementation has been driven and enacted by the states and territories.

The early policies agreed by the Australian Health Protection Principal Committee (AHPPC) and implemented by the Australian Government and state and territory governments have reduced initial pressure on our healthcare system, ensuring it is ready to cope with potential future waves of infection as society gradually reopens.

Specialist GPs have responded decisively and proactively to the pandemic emergency. In just a few weeks, general practices have implemented significant changes to the way they work. They have developed creative new ways of working in order to continue to deliver safe and essential care to their communities. For example, GPs set up outdoor clinics to deliver influenza vaccinations, established respiratory clinics, have rapidly embraced telehealth and overcome many technical and system challenges in the process.

The pandemic has highlighted how essential the role of general practice is in responding to emergencies. As the cornerstone of Australia's health system seeing 85% of the population every year,[2] GPs and their teams can and should be central to national, state and regional emergency planning. Unfortunately, this is often not the case, with GPs extremely concerned about the ongoing exclusion of primary healthcare from emergency or pandemic planning.

Additionally, the pandemic has had a significant impact on the viability of general practices and the ability of GPs to provide holistic care to their patients. Income has fallen sharply as people stay at home and put off seeing their GP, and MBS billing restrictions for telehealth items remain in place. The pandemic has also exposed some of the failings in the government's funding model for general practice and highlighted the need to abolish onerous and archaic rules and regulations governing how care is provided.

There is a strong sense that more could have been done – both in the early stages of the pandemic and as it has progressed – to support GPs in their role as frontline healthcare workers. To ensure GPs and their teams are better positioned to respond to future waves of COVID-19 (or other outbreaks of infectious disease) and deal with the expected rise in other health issues caused by the pandemic, further action is urgently needed.

Due to the unprecedented nature of the pandemic, some errors and oversights are inevitable. However, it is vital the lessons from this pandemic help inform Australia's response to any future infectious disease outbreaks. The Australian Government's response should be challenged to ensure Australia is well prepared to respond to similar challenges in a timely manner, while minimising the negative economic and social impacts as much as possible.

Our submission makes recommendations in section 2 on opportunities for enhancing the response both immediately and in the long term, with detailed discussion of these recommendations in section 3.

2. Recommendations

2.1. Urgent recommendations

Topic	Recommendations
Impact of the pandemic on patients (section 3.1 of submission)	1. The Australian Government should invest in a range of public media and communications campaigns which highlight the importance of not delaying seeing a GP and accessing essential treatment, whether for existing health conditions or new symptoms.
Access to and use of PPE (section 3.2)	2. Government should urgently address the supply shortages of PPE (P2/N95 masks, gloves, gowns and eyewear) to GPs and general practices.
COVID-19 MBS telehealth items (section 3.3)	3. The *Health Insurance (Section 3C General Medical Services – COVID-19 Telehealth and Telephone Attendances) Amendment (Bulk-billing) Determination 2020* should be immediately amended to remove the bulk billing requirement for MBS telehealth items for general practice services.
Medicare compliance processes (section 3.5)	4. The Department of Health should issue a statement to alleviate concerns about compliance processes during and after the pandemic.
Financial support and assistance for practices (section 3.6)	5. The fall in turnover threshold for the JobKeeper Payment should be lowered from 30% to 15% for general practices. 6. Practice Incentives Program and Workforce Incentive Program – Practice Stream payments should be reviewed and increased (similar to the doubling of the Practice Incentives Program Quality Improvement [PIP QI] Incentive). 7. Financial assistance should be provided to support GPs in training.
Pathology rental agreements (section 3.8)	8. The six month moratorium on new pathology collection centre leases should be lifted to reduce the likelihood of predatory behaviour during these difficult circumstances.

2.2. Short-term recommendations

Topic	Recommendations
Influenza vaccinations (section 3.9)	9. Adequate supply of influenza vaccinations – National Immunisation Program (NIP) and private – should be prioritised for general practices before supplied to pharmacies. 10. Provision of NIP vaccinations should be contingent on the ability to upload relevant information to the Australian Immunisation Register.
Communication and collaboration with GPs (section 3.11)	11. Where possible, Primary Health Networks (PHNs) and/or state health bodies should provide GPs with access to: – government modelling and local descriptive epidemiological data – clear, concise and accessible evidence-based information on clinical care for different population groups, especially those vulnerable and at higher risk – timely information regarding patient COVID-19 test results, including via My Health Record

Topic	Recommendations
	– information regarding patient admission or discharge from hospital or other services 12. Evidence-based advice should be provided on how to care for different population groups with varying needs during the pandemic.
Preventing the spread of misinformation (section 3.12)	13. The Australian Government should fund a public awareness campaign to educate Australians about the importance of immunisations, and heeding the advice of medical experts rather than celebrities who promote views contrary to scientific evidence.
Aboriginal and Torres Strait Islander people (section 3.13.2)	14. Additional funding should be provided to support Aboriginal and Torres Strait Islander people during the pandemic. There should be a particular focus on delivering culturally appropriate preventive health activities, and addressing social determinants of health to ensure community preparedness for future pandemics.
People from CALD backgrounds, refugees and asylum seekers (section 3.13.4)	15. Greater financial assistance should be provided for people without work rights and those unable to access support through the Status Resolution Support Services program. 16. Targeted education should be provided in different languages, tailored to varying health literacy levels, around COVID-19 testing, treatment, public health management strategies, the implications of a positive test and the need for self-isolation.

2.3. Medium to long-term recommendations

Topic	Recommendations
Access to and use of PPE (section 3.2)	17. The role of PHNs in distributing PPE should be examined. 18. Planning for future pandemics should include the establishment of distribution channels for PPE that are able to respond to local requirements. 19. There must be clear and honest messaging regarding PPE availability. 20. Communication channels should be established to issue advice regarding PPE. 21. Clear advice on the appropriate use of PPE should be based on national guidance.
Funding for research into the efficacy of care delivered via telehealth (section 3.3.6)	Funding should be provided for research into: 22. how to ensure the provision of high-quality care via telehealth for the treatment and management of a range of health conditions 23. the impacts of a large-scale adoption of telehealth on general practices (during and post pandemic) to assist with the allocation of future funding 24. the role of telehealth in Aboriginal and Torres Strait Islander primary healthcare.
Future of telehealth services beyond September 2020 (section 3.4)	25. Access to Medicare-funded telehealth services for all Australians should continue to be available beyond 30 September 2020 (when the temporary COVID-19 MBS telehealth items are scheduled to expire). 26. Measures to support the relationship of the patient with their usual provider should be instituted to limit the increase in profit-driven on-demand telehealth services.
Medicare compliance (section 3.5)	27. The Department of Health should exercise discretion when undertaking compliance investigations due to the uncertain nature of the pandemic.

Topic	Recommendations
Ensuring secure messaging in healthcare (section 3.7)	28. Before implementing system changes and technical solutions, the government must consult closely with general practice stakeholders to ensure minimal impact on existing general practice workflows and systems. 29. A centralised exchange server should be developed by the Australian Digital Health Agency for the purposes of pathology and imaging requesting.
Influenza vaccinations (section 3.9)	30. Annual supply for influenza vaccinations should be calculated using Standardised Whole Patient Equivalent values.
Point of care testing (section 3.10)	31. PoCT should be made accessible via general practice, supported by Medicare rebates, and regulatory barriers to its adoption in general practice should be removed.
Communication and collaboration with GPs during the pandemic (section 3.11)	32. A nationally consistent set of criteria for testing infectious disease should be developed to minimise confusion. 33. An RACGP representative should sit on the AHPPC. 34. There should be formal and permanent GP representation on state and territory health management committees. 35. Each jurisdiction should establish a pandemic response plan that is exercised, reviewed and updated regularly with the involvement of GPs. 36. State-based health response roundtables should be established. 37. Involvement of GPs and other primary care practitioners in PHNs, hospital districts and other coordinating health and emergency response services should be increased. 38. A national coordinated body should be established to prevent inconsistent public messaging.
Matters for further consideration, including social consequences of the pandemic (section 3.14)	39. Increased funding and resources should be provided to support GPs to respond to a predictable increase in mental health issues, domestic violence and poverty as a result of the pandemic.

3. Discussion

3.1. Impact of the pandemic on patients

3.1.1. Issue

The COVID-19 pandemic has had a significant impact on people seeking care from their GP. Patient attendances have fallen dramatically due to concern about contracting the virus.[3] As not all health issues can be managed or treated via telehealth, and some patients are not comfortable with using telehealth, it is critical that people are not deterred from seeking face-to-face care when they need it.

3.1.2. Member feedback and RACGP position

General practices remain open for business during the pandemic, with almost 97% of respondents to a recent RACGP survey currently offering patients face-to-face consultations. This is in stark contrast to other services in the community that have closed, such as hospital outpatient clinics or maternal and child health centres, with patients instead seeking face-to-face appointments with GPs due to the temporary closure of these facilities.

Despite this, RACGP members report people with serious health conditions such as diabetes, heart disease, asthma and hypertension are not having their condition reviewed by their GP and are missing important routine checks. The risks

associated with a lack of ongoing management of common medical conditions is substantially higher than the small risk of exposure to COVID-19 while visiting a general practice. Practices have robust systems in place for infection prevention control and management.

Further reports suggest cancer referrals at Australia's leading oncology centres have fallen by up to 30%, with the Peter MacCallum Cancer Centre in Melbourne reporting a drop in referrals by a third during April 2020.[4] These figures indicate that patients are not presenting to their GP with early symptoms. There has also been a reported 50% decline in pathology testing.[4]

The consequence of this will be late or missed diagnoses, poorer health outcomes and increased costs to the health system from delayed treatment.

To support and encourage patients to seek care during the pandemic, the RACGP felt compelled to invest in our *Expert Advice Matters* campaign, urging all patients to take care of their health and wellbeing during the COVID-19 pandemic and consult with their usual GP for any health concerns.

Patients, especially older people and those in vulnerable populations and at higher risk, must be reassured that it is safe to attend general practices as they have rigorous processes in place to protect patients from infection.

These include (but are not limited to):

- phone triage
- patients waiting for an appointment in the car rather than the waiting room
- fever screening and/or further reception triage upon entry
- partitioned spaces (eg dedicated consultation rooms/sections of the practice for patients with and without respiratory issues)
- social distancing inside the clinic
- appropriate use of hand sanitiser and PPE.

The RACGP recommends:

- the Australian Government invest in a range of public media and communications campaigns which highlight the importance of not delaying seeing a GP and accessing essential treatment, whether for existing health conditions or new symptoms. *(Recommendation 1)*

3.2. Access to and use of personal protective equipment (PPE)

3.2.1. Issue

PPE includes masks, gloves, gowns and protective eyewear. They are necessary to examine patients safely and effectively. This is critical to protect healthcare workers, their families and the communities in which they live, as well as patients attending face-to-face consultations. However, timely access to PPE has been highly variable across Australia.

3.2.2. Member feedback and RACGP position

Provisions should have been made earlier to protect GPs as frontline health workers. GPs are unable to provide care to their patients safely without proper PPE. The need for this equipment is particularly acute when consulting with patients who may have COVID-19 but have not yet been tested or are awaiting results. The delay in receiving results has also contributed to concerns with reviewing these patients and problems with people wanting to return to work. GPs and other practice staff have reported waiting between five and eight days for results, despite the urgency. This has been variable across Australia but is significant and a disincentive for appropriate persons to present for testing.

At a time when GPs are contending with a significant fall in revenue, they require urgent access to federal and state emergency stockpiles of PPE. During a pandemic such as this, GPs on the frontline should not be expected or required to source private supplies of PPE.

During the pandemic, members reported:

- instances where they were being encouraged or compelled to reuse the same equipment, which is unsafe
- having to source PPE privately at excessive retail prices, with suppliers and other stockists (eg Bunnings) often out of stock
- resorting to homemade equipment (eg masks and face shields) due to shortages
- shortages of hand sanitiser, which is currently difficult to obtain at a reasonable price
- confusion and a lack of transparency regarding supply and distribution
- a lack of timely advice and training regarding correct use of PPE when conducting face-to-face consultations (during the early stages of the pandemic)
- feeling unsafe to work due to lack of PPE
- a decline in GP morale due to limited PPE distribution despite reassurances additional stock would be made available.

Distribution of PPE

Primary Health Networks (PHNs) were tasked with the distribution of PPE. The logistical challenges faced in ensuring PPE was made available where it was needed most appeared to overwhelm some PHNs, resulting in restricted access for practices.

Distribution of PPE needs to be supported by a consistent and transparent process to ensure:

- general practices are supplied according to their needs based on patient numbers and confirmed infection rates in local areas
- proactive assistance to obtain additional PPE is provided when PHN stockpiles have depleted.

The RACGP recommends:

- government urgently address the supply shortages of PPE (P2/N95 masks, gloves, gowns and eyewear) to GPs and general practices *(Recommendation 2)*
- the role of PHNs in distributing PPE be examined *(Recommendation 17)*
- planning for future pandemics include the establishment of distribution channels for PPE that are able to respond to local requirements *(Recommendation 18)*
- there be clear and honest messaging regarding PPE availability *(Recommendation 19)*
- communication channels be established to issue advice regarding PPE *(Recommendation 20)*
- clear advice on the appropriate use of PPE be based on national guidance *(Recommendation 21)*.

3.3. COVID-19 Medicare Benefits Schedule (MBS) telehealth items

3.3.1. Background

The introduction of temporary COVID-19 MBS telehealth items to support telephone and video consultations in general practice was a critically important development. Prior to the introduction of these items, the MBS only supported access to care delivered via telehealth in very limited circumstances. The items were introduced in several stages and first introduced on 13 March 2020.

3.3.2. Positive aspects of service delivery via telehealth

Given the significant logistical task of creating new MBS item numbers and descriptors for a range of services, the swift introduction of COVID-19 telehealth items after significant RACGP advocacy has been welcomed by our members. It is pleasing that, in the midst of a pandemic, the need for telehealth was recognised so quickly.

GPs have noted that funding for MBS telehealth items in general practice is long overdue. The RACGP has been a vocal advocate for the introduction of alternative models of care for patients who are unable to attend a practice in person.[5]

GPs have adapted quickly to providing care during the pandemic, with significant and rapid uptake of the new MBS telehealth items. A recent RACGP survey found 99% of practices are facilitating telehealth consultations.

GP feedback indicates that MBS telehealth services have:

- enabled GPs to continue providing essential care while minimising the risk of COVID-19 infection
- ensured practices can remain operational while protecting staff and patients
- provided opportunities for GPs to connect with and support patients through an incredibly stressful time that otherwise would not have been possible
- provided flexibility for GPs with childcare responsibilities or in high risk population groups to continue providing care to their patients
- given patients a range of options to access care safely and remotely due to the availability of different telehealth platforms (eg by phone or video)
- reduced waiting and travel time for patients
- enabled older GPs and those at greater risk of COVID-19 infection to continue working and earning an income
- been beneficial for patients with mental health issues, particularly mild to moderate anxiety/stress
- helped to equalise access to healthcare between urban and rural/remote communities. Patients in rural and remote areas now have access to a broadened range of healthcare services and providers. Other benefits for these patients include savings in travel time and costs, no lost productivity due to absences, and not having to leave their home or farm, which in some cases might be detrimental to their health.

3.3.3. Issue

While the introduction of telehealth items was well received by the sector, a number of key issues surfaced which have had a detrimental impact on GPs and general practices.

These issues include:

- ambiguity in understanding changes in telehealth services with the staged roll out of items
- mandatory bulk billing requirements.

<u>Staged introduction of telehealth services and changes to eligibility criteria created significant issues</u>

RACGP members have reported the staged introduction of the telehealth item numbers was an unnecessarily over-complicated and confusing process. 'Whole of population' telehealth services should have been introduced when funding for telehealth was first announced.

Members have advised the staged approach to the COVID-19 telehealth items:

- significantly increased costs to practices as a result of having to:
    - frequently adjust billing systems
    - provide education and training to staff on the new items – particularly which patients can access telehealth and whether or not they must be bulk billed
    - educate patients regarding service options and fees

- resulted in loss of revenue due to software vendors being unable to keep up with changes to the items
- created disruptions for practices and made it difficult to create stable workflows, largely due to time spent educating staff about the changes
- were unnecessarily complex in comparison to other medical service fee structures (eg workers' compensation schemes), where no further changes were implemented following the initial release of items
- enhanced the possibility of errors being made when billing the items
- forced GPs to review and adapt their business models repeatedly during this time of crisis
- resulted in reception staff having to answer more questions about billing from confused patients.

Members also reported some initial requirements of the MBS items were inconsistent with the intent of the telehealth items, such as the need for a physical signature to be provided by a patient who is bulk billed to assign their benefit as full payment for the service.

Commendably, the Department of Health's responsiveness to feedback from the health sector and commitment to finding solutions quickly has helped to address some issues with the telehealth items in a timely manner.

Telehealth bulk billing requirement

Initially, it was compulsory to bulk bill all patients when using the new items. The bulk billing requirement was partially relaxed on 6 April 2020.

However, the legislative requirement that telehealth services provided by GPs be bulk billed for Commonwealth concession card holders, children under 16 years old and patients who are more vulnerable to COVID-19 remains.

From 20 April 2020, other medical specialists and allied health professionals were permitted to privately bill all COVID-19 telehealth consultations.

The RACGP has received numerous enquiries from concerned GPs and practice staff who have described this decision as inequitable and detrimental to the viability of their practices, impacting their ability to provide care for their patients.

3.3.4. Member feedback and RACGP position

The RACGP recognises millions of people across Australia have been affected financially by the pandemic. We fully support access to frontline healthcare for patients, particularly those who are vulnerable and at greater risk of COVID-19 complications.

However, it is not acceptable the bulk billing requirement has been applied to particular health professionals and not others. During these challenging times, GPs should be trusted to apply their usual billing practices and exercise discretion where necessary (eg if patients are clearly unable to afford a gap fee).

The financial viability of practices is under threat in part because GPs are unable to charge a co-payment for a larger percentage of patient consultations. This is despite the financial benefits and broader range of services and facilities privately billing practices offer. Members have observed practices that charge private fees cost the government less money per hour due to their capacity to offer longer, more comprehensive consultations, including discussions regarding preventive health and self-management.

The viability of many practices across Australia has already been impacted as a result of the longstanding Medicare rebate freeze and natural disasters such as Australia's recent devastating bushfire season. Practices affected by the bushfires provided vital support to devastated communities in a time of severe adversity and are needed to support these communities as the recovery process continues in the months and years ahead.

The introduction of doubled bulk billing incentive payments for vulnerable patients is welcomed. However, some members report these are not sufficient to cover their expenses and are far below the gap fee they would usually charge when billing privately.

If practices are forced to close as a result of this requirement, patients will no longer have access to high-quality, locally accessible general practice care. The results of this would be devastating to the health and wellbeing of the community and the capacity of the broader healthcare system.

Consequences of the bulk billing requirement

Member feedback indicates the bulk billing requirement:

- is contributing to significant loss of income, with most practices reporting between 10–60% loss of revenue compared to the same time last year
- has left GPs struggling to cover essential and increased practice costs
- is threatening the viability of smaller, privately-owned clinics
- disincentivises GPs to spend more time with patients and provide preventive care
- has forced GPs to bulk bill patients who can afford to pay for healthcare and expect to be charged in line with pre-COVID-19 billing arrangements
- has created uncertainty for privately billing practices that have established fixed costs in line with an expectation that they can charge private fees
- has impacted negatively on the mental health and wellbeing of GPs and practice teams
- is further lowering morale in the profession, with GPs feeling inadequately valued at a time they are providing critical frontline care
- has resulted in further distrust of Medicare and its systems
- is prompting GPs to question whether general practice will be a viable future career option
- will discourage medical students from wanting to enter the profession and drive down rates of enrolment into the Australian General Practice Training Program.

Understanding the impact on practice viability – the general practice landscape in May 2020

The RACGP sought feedback from members on the impact of the telehealth bulk billing requirement on the viability of their practice via an online survey. Almost 1000 responses were received. The survey results revealed:

- nearly 60% of respondents either strongly agreed or agreed that the bulk billing requirement has affected the viability of their practice
- over 70% of respondents are bulk billing more patients than usual
- 43% of respondents have experienced a 10–30% decrease in revenue compared to the same time last year, while 27% have experienced a 30–60% decrease
- most respondents (71%) thought continuing telehealth items after the COVID-19 pandemic will support patient access to high-quality care in general practice.

Other issues resulting from the bulk billing requirement

These additional issues contribute to the complications of the bulk billing requirement:

- difficulty determining patient eligibility for bulk billing
- the wide application of the 'chronic health condition' criteria, where some GPs are finding they are essentially required to bulk bill every patient they see due to the prevalence of chronic disease within the general population
- MBS rebates for bulk billed telehealth consultations are too low to cover the cost of delivering high-quality general practice care.

The RACGP recommends:

- the *Health Insurance (Section 3C General Medical Services – COVID-19 Telehealth and Telephone Attendances) Amendment (Bulk-billing) Determination 2020* be immediately amended to remove the bulk billing requirement for MBS telehealth items for general practice services *(Recommendation 3)*.

Amending the legislation would allow the bulk billing requirement specified in the item descriptors for MBS telehealth items for general practice services (sentence highlighted below in bold and yellow) to be removed.

Example: Item descriptor for MBS item 91800 (Telehealth attendance by a general practitioner lasting less than 20 minutes)

Telehealth attendance by a general practitioner lasting less than 20 minutes if the attendance includes any of the following that are clinically relevant:

(a) taking a short patient history;
(b) arranging any necessary investigation
(c) implementing a management plan;
(d) providing appropriate preventative health care;

NOTE: It is a legislative requirement that the service must be bulk-billed where the service is provided to a concessional or vulnerable patient at the time the service is provided. For all other patients the service may be bulk-billed.

3.3.5. Short-term recommendations to improve telehealth services

There are additional ways to enhance GP service offerings via telehealth in the short term, as outlined in Appendix A.

3.3.6. Funding for research into the efficacy of care delivered via telehealth

Member feedback and RACGP position

The COVID-19 pandemic has highlighted the willingness of patients and health practitioners to embrace new models of service delivery. Telehealth offers numerous benefits and has demonstrated that care can be equally effective when delivered remotely, challenging traditional conceptions of the doctor-patient relationship.

Telehealth is now a widely accepted tool used to provide care, and one that should continue to be available after the pandemic as it will permanently help reduce the spread of disease.

However, decreases to the number of face-to-face services in the future could potentially reduce the quality of care provided to patients. While telehealth is now an essential part of the healthcare landscape, face-to-face care is still the optimal mode of service delivery and provides greater opportunities to examine patients, diagnose and treat medical conditions. The RACGP considers telehealth to be complementary to, rather than a substitute for, face-to-face care.[6]

Aboriginal and Torres Strait Islander health

A practical evaluation of the role of telehealth in Aboriginal and Torres Strait Islander primary healthcare is required to better understand barriers and enablers to uptake, and the quality of healthcare provided. An equity-based approach, which examines a range of variables, including the geographic breakdown of access, availability of functioning digital tools and patient and clinician experience, will ensure a greater understanding of the value of telehealth in this context.

Further information regarding the impact of the pandemic on Aboriginal and Torres Strait Islander people is provided below in section 3.13.2.

To support optimal delivery of health services via telehealth now and into the future, the RACGP recommends funding be provided for research into:

- how to ensure the provision of high-quality care via telehealth for the treatment and management of a range of health conditions *(Recommendation 22)*
- the impacts of a large-scale adoption of telehealth on general practices (during and post pandemic) to assist with the allocation of future funding *(Recommendation 23)*
- the role of telehealth in Aboriginal and Torres Strait Islander primary healthcare *(Recommendation 24)*.

3.4. Future of telehealth services beyond September 2020

3.4.1. Issue

The RACGP considers telehealth to be an essential form of service delivery, particularly in the current climate, and has long called for the expansion of telehealth services to the entire community to support access to care. Consumers also report appreciating the flexibility telehealth offers.[7]

3.4.2. Member feedback and RACGP position

Our members report extending access to telehealth services beyond COVID-19 would allow time to gradually alleviate patient concerns about the safety of receiving face-to-face care. In the absence of a COVID-19 vaccine, the continuation of telehealth could also form part of an ongoing strategy to reduce the risk of infection in the community.

Rural, regional and remote areas

Members report patients in rural, regional and remote areas require ongoing access to telehealth services to ensure parity of health outcomes with their metropolitan counterparts. Patients in these areas often have to travel long distances to access vital care.

On-demand telehealth services

The expansion of telehealth and telephone MBS items has seen a surge in telehealth models and businesses that operate models of care that are often profit-driven and may compromise patient safety.

The RACGP has significant concerns about these on-demand telehealth and telephone services that do not provide a link to a patient's usual general practice, which is essential for continuity of care. There are additional concerns with privacy and, at times, the inappropriate and unapproved use of patient data, both during and after a consultation.

Some of these services are taking advantage of understandable anxieties in the community about contracting COVID-19 and expanding their own business models with public funding through the MBS. This poses considerable risks to the health and wellbeing of the community and the viability and reputation of high-quality and patient-focussed general practice care.

Our position statement on on-demand telehealth services outlines the RACGP's view that telehealth services should be provided by a patient's usual GP or practice wherever possible. This is to ensure the delivery of safe, necessary and appropriate care. GPs providing care to known patients have access to a patient's notes and history and awareness of individual circumstances and needs.

Telehealth provides an opportunity for remote monitoring and the management of chronic conditions, providing flexibility, improving convenience and potentially reducing costs for both patients and GPs.

The RACGP's *Vision for general practice and a sustainable healthcare system* highlights the importance of developing an ongoing therapeutic relationship with a usual GP to support continuity of care across patients' lifespan.

The RACGP recommends:

- access to Medicare-funded telehealth services for all Australians continues to be available beyond 30 September 2020 (when the temporary COVID-19 MBS telehealth items are scheduled to expire) *(Recommendation 25)*
- measures to support the relationship of the patient with their usual provider be instituted to limit the increase in profit-driven on-demand telehealth services *(Recommendation 26)*.

3.5. Medicare compliance processes

3.5.1. Issue

Measures aimed at preserving the integrity of Medicare and use of health resources by preventing wrongful and fraudulent claiming are supported by the RACGP ('in principle'). However, fear of compliance measures and audit remain a constant for most GPs when they practice.

GPs do not need the additional fear of audit when adapting their practice to continue to provide care to their patients during a pandemic or emergency. Providers have been required to make adjustments to the way they practice and the Department of Health should provide reassurance that these adjustments (if reasonable) will not result in a compliance investigation once the COVID-19 situation eases.

3.5.2. Member feedback and RACGP position

Members have expressed a desire for discretion to be applied by the Department of Heath when it inevitably commences Medicare compliance activities after the pandemic. The RACGP expects that practitioners who have provided services that are clinically indicated and within the intent of usual Medicare billing guidelines – even if these vary from patterns of usual billing – will be treated with understanding and lenience (with respect to compliance measures).

The RACGP recommends the Department of Health:

- issue a statement to alleviate concerns about compliance processes during and after the pandemic *(Recommendation 4)*
- exercise discretion when undertaking compliance activities due to the uncertain nature of the pandemic *(Recommendation 27)*.

3.6. Financial support and assistance for practices

3.6.1. Issue

Financial assistance for businesses was provided by the Australian Government in a timely manner; however, the eligibility criteria for the support package has made it difficult for general practices to access this essential support.

3.6.2. Member feedback and RACGP position

JobKeeper Payment

Many practices have reported they are not eligible for the JobKeeper Payment as some have not experienced a 30% reduction in turnover. Eligibility for JobKeeper does not align with the nature of general practice, as working hours and clinical commitments of GPs can change frequently.

The focus on turnover hides the impact of COVID-19 on new practices or practices that have recently expanded their business models. Additionally, it does not take into account that many practices have had to greatly increase expenditure (eg on administrative staff, PPE, telehealth systems, internet connection improvements) to manage the increased demands imposed by COVID-19 regardless of income.

Furthermore, many small businesses are subject to the vagaries of cash flow. Even if a practice is eligible, the JobKeeper Payment requires a business to pay the full amount to staff before reimbursement by the Australian Taxation Office. This may not be possible for many general practices.

Practices may not qualify for the JobKeeper Payment because their loss of revenue has been offset by a temporary boost in income from administering influenza vaccinations in April 2020. This is an outcome of patients being encouraged by the government and health experts to get their annual influenza vaccination earlier than usual this year in response to COVID-19.

RACGP members have reported that the JobKeeper Payment:

- would benefit practices that have experienced a significant financial downturn but do not currently meet the JobKeeper qualification threshold. These practices are supporting nursing and reception staff where there may not currently be a need for these staff to be working regular hours
- is, overall, unlikely to be sufficient to keep practices that have been severely affected by the pandemic afloat. Many GPs work part-time as sole traders and will struggle to recover financially. They may also have other employment on a minimal part-time basis which can preclude them from accessing the payment
- lacks clarity on eligibility requirements and is difficult to navigate, particularly for sole traders
- will only offer temporary relief to businesses, with staff lay-offs inevitable once the JobKeeper period ends.

Increased volume of calls to general practices

Throughout the pandemic, governments have been encouraging people to call their GP if they suspect they may have contracted COVID-19. While this is recommended to protect the safety of GPs and practice staff and allow time to prepare for the consultation, practice staff have been inundated with calls, which has prevented them from performing other critical duties. No funding assistance has been provided to support the additional resources required to answer these calls (noting the limits to the funding model in general practice).

Members are also reporting that their reception staff are further engaged in proactively calling regular patients to inform them of changes and reassure them of the availability of safe and high-quality care during this period.

GPs in training

Members report GP registrars (GPs in training) are currently suffering in terms of workflow, income and educational opportunities.

In mid-April 2020, almost one in three GPs in training reported they had needed to take leave due to self-isolation or illness. Some report they were able to work from home during isolation, however many others needed to use their personal or annual leave allowances. For nearly 10% of trainees, this leave was unpaid.[8]

Three in four GPs in training reported a decrease in their patient load since the COVID-19 pandemic, and for half of these this has been a significant decrease. Thirteen per cent reported their hours had been reduced, and a further 5% reported their employer was considering reducing their hours.[8]

One suggestion raised by members is to treat GP registrars as apprentices, allowing them access to apprentice support networks.

Impact of financial losses on future recruitment of doctors

Feedback from our members indicates the financial losses suffered by GPs during the pandemic will affect the future viability of general practice as a career option, which is already under significant threat as medical trainees increasingly choose to pursue other specialisations.[9] It will be difficult to convince young doctors to pursue a career in general practice if the profession continues to be undervalued in comparison to other medical specialties.

This will severely impact vulnerable people in the community, particularly older people and those with chronic health conditions. There would be fewer GPs available and pressure on hospitals would increase substantially. This is a particularly pressing issue for rural and remote communities.

To improve financial support for practices and GP trainees, the RACGP recommends:

- the fall in turnover threshold for the JobKeeper Payment be lowered from 30% to 15% for general practices *(Recommendation 5)*
- Practice Incentives Program and Workforce Incentive Program – Practice Stream payments be reviewed and increased (similar to the doubling of the Practice Incentives Program Quality Improvement [PIP QI] Incentive *(Recommendation 6)*
- financial assistance be provided to support GPs in training *(Recommendation 7)*.

3.7. Ensuring secure messaging in healthcare

3.7.1. Issue

The move to telehealth consultations has created a number of legislative and technical challenges, one of the most significant being how to manage prescribing, which is still a paper-based process (although the infrastructure for electronic prescribing has existed for some time).

This situation has also highlighted the lack of electronic requesting of pathology and imaging services, as well as an inability to safely and securely handle other documents electronically, such as medical certificates, medical reports and other communications with patients and other interested persons.

3.7.2. Member feedback and RACGP position

The RACGP welcomed the interim arrangements put in place for telehealth prescriptions, which enabled prescribers to create an image of the prescription to send on to the patient's pharmacy of choice via email, text message or fax. Prescribers were afforded the flexibility to then retain the paper prescription for a period of two years, reducing the administrative and financial burden of sending these to pharmacies.

Difficulties with national implementation of this process arose out of the reluctance of some states to make the necessary legislative changes in a timely manner. This demonstrates the need for a consistent national approach when changes are required to support the pandemic response.

The government has also said it intends to fast-track the roll out of its planned electronic prescribing initiative. The RACGP broadly supports the fast-tracked roll out. However, it is not anticipated there will be a significant uptake given the success and adoption of telehealth image-based prescribing, which has utilised and adapted existing technologies and processes. The electronic prescribing initiative will introduce new technologies and systems, which at this time, will be challenging for general practice and the pharmacy sector to implement.

The issue of pathology and imaging requesting could be addressed through the development of a centralised exchange server, similar to those used for prescriptions. This could prevent proprietary systems for each individual company, with patient access restricted to those companies. The RACGP recommends this body of work be led by the Australian Digital Health Agency.

The RACGP recommends:

- before implementing system changes and technical solutions, the government consult closely with general practice stakeholders to ensure minimal impact on existing general practice workflows and systems *(Recommendation 28)*
- a centralised exchange server be developed by the Australian Digital Health Agency for the purposes of pathology and imaging requesting *(Recommendation 29)*.

3.8. Pathology rental agreements

3.8.1. Issue

A major consequence of the pandemic for general practices has been the need to negotiate rental agreements with pathology companies seeking rent relief. The RACGP is aware there has recently been a significant drop in patients presenting for pathology collection due to the pandemic. This in turn has affected the viability of pathology companies, and they are therefore exploring options to reduce overhead costs.

3.8.2. Member feedback and RACGP position

Negotiations have been complicated by the Australian Government's decision to place a six month moratorium on the establishment of pathology collection centre leases. This has placed general practices at a disadvantage during negotiations. The RACGP sought feedback from members on their experiences negotiating rental agreements. Of those who responded, 43% either disagreed or strongly disagreed that negotiations they have had with a pathology company during this process felt open and genuine.

In effect, general practice owners are being forced to either accept a reduction in rent, as proposed by the pathology company, or have a vacant room with no opportunity to re-negotiate rental arrangements with another pathology company. This measure has further compromised the viability of general practices to keep their doors open.

The RACGP recommends:

- the six month moratorium on new pathology collection centre leases be lifted to reduce the likelihood of predatory behaviour during these difficult circumstances *(Recommendation 8)*.

3.9. Influenza vaccinations

3.9.1. Issue

Issues around the supply and distribution of influenza vaccines across the country continue to persist, despite official advice issued to the public that it was imperative to get vaccinated earlier this year.

3.9.2. Member feedback and RACGP position

Members report that:

- patients have expressed frustration that they have been unable to access influenza vaccinations due to a lack of available stock, with receptionists fielding numerous enquiries
- patients were encouraged by the government to get their influenza vaccination before stock was available
- better public communication around influenza vaccinations is required. Politicians and public health advisors need to advise the public that GPs are only given a controlled amount of vaccines and have no control over stock being used and can only reorder at set periods

- in some cases pharmacies are receiving stock before general practices.

In a poll of over 1000 RACGP members in late April 2020, 55% reported that they are unable to access enough stock to provide influenza vaccinations to their patients.

Timely and adequate supply of National Immunisation Program (NIP) influenza vaccinations for practices is a recurring issue each year. The RACGP has requested information from the Australian Government on how supply is managed, including the methodology used to calculate demand/supply and distribution planning, to support discussions to improve access to influenza vaccinations in the future.

Pharmacy vaccination programs fragment patient care and impact on patient safety. They also reduce opportunities for effective vaccine counselling as well as opportunistic screening and preventive healthcare activities. Providers should not be permitted to administer influenza vaccinations through the NIP if they are unable to upload information to the Australian Immunisation Register. This occurs automatically in most general practices but only sporadically in pharmacies.

The increased early demand in 2020 could not have been anticipated, however using Standardised Whole Patient Equivalent values could provide accurate data on the number of patients in each PHN catchment area.

The RACGP recommends:

- adequate supply of influenza vaccinations – NIP and private – be prioritised for general practices before supplied to pharmacies *(Recommendation 9)*
- provision of NIP vaccinations be contingent on the ability to upload relevant information to the Australian Immunisation Register *(Recommendation 10)*
- annual supply for influenza vaccinations be calculated using Standardised Whole Patient Equivalent values. *(Recommendation 30)*.

3.10. Point of care testing (PoCT)

3.10.1. Issue

Although not currently available, if reliable point of care testing (PoCT) for COVID-19 became available, this could be performed as a first step in the clinical assessment of someone with possible COVID-19 in general practice.

The advantages of such an approach to controlling a future pandemic are obvious. However, PoCT is largely not feasible in general practice at this time because of unnecessary regulatory barriers.

It is the position of the RACGP that evidence-based PoCT should be accessible via general practice through Medicare and regulatory barriers to its adoption in general practice must be removed.

3.10.2. Member feedback and RACGP position

General practice has the capability to efficiently and effectively undertake PoCT. If supports were provided via Medicare and all regulatory barriers removed, the sector could have been performing PoCT for all strains of influenza, reducing the amount of COVID-19 testing in the early stages of the pandemic when resources were limited.

Additionally, the RACGP notes the Australian Government's announcement of funding for a COVID-19 Remote Point of Care Testing Program.[10] As the program is in the early stages of roll out, it is difficult to provide comment. However, there is a need to consider issues such as staffing capacity and training, appropriate facilities and availability of testing. Simply making the tests available is not in and of itself sufficient. The capital expenditure required to support the roll out must also be appropriately considered.

The RACGP recommends:

- PoCT be made accessible via general practice, supported by Medicare rebates, and regulatory barriers to its adoption in general practice be removed *(Recommendation 31)*.

3.11. Communication and collaboration with GPs during the pandemic

3.11.1. Issue

Although there has been an abundance of communication regarding the pandemic, there have been issues around the timeliness of information and confusion regarding state-based requirements.

The RACGP has made efforts to disseminate information to our members in a timely manner, including frequently updating our website based on announcements from government and dedicated bi-weekly newsletters.

3.11.2. Member feedback and RACGP position

Management of the pandemic response at different levels of government

The RACGP recognises different levels of government and agencies have different roles and responsibilities relating to managing the pandemic response. However, the cross-jurisdictional and inter-agency roles must be better coordinated and streamlined.

Efforts to embed GPs in the wider response have been confused and at times non-existent due to state and territory governments' management of the health crisis response and the federal government's responsibility for general practice. The RACGP has consistently flagged these issues over the years and will continue to work with state and federal government pandemic response structures to bridge this gap.

The role of GPs as frontline health providers must be formally recognised in pandemic preparation, response and recovery. GPs have continuous relationships with their communities before and during health emergencies, including opportunistic encounters with patients due to the high demand for primary care. General practice should therefore be firmly embedded in national and state/territory planning.

As federally funded organisations tasked with local primary care coordination, and efficiency and effectiveness of medical services, PHNs should be supported to better integrate general practice and primary healthcare into pandemic response planning, coordination and recovery, in close consultation with GPs and GP bodies.

The experience during the current pandemic and the recent bushfire crisis has highlighted the variability in PHN preparedness. Areas with lower levels of preparation experienced poor linkage and coordination, with inconsistent messaging to general practices operating in their areas, creating confusion and division. The requirement for a national, uniform approach to PHN engagement with general practices before, during and after health emergencies would alleviate some of this confusion.

Other issues raised by members in regard to confusing messaging during the pandemic include:

- different testing criteria across the country
- inconsistent advice from politicians to get tested, despite a shortage of swabs and strict criteria around who would be eligible for testing
- different advice regarding use of PPE
- a lack of cohesion between the federal and state and territory governments.

Information around providing care to different population groups

Member feedback suggests there is a need for evidence-based advice to be provided on how to care for different population groups with varying needs during the pandemic.

For example, members report minimal accessible information has been issued on how to advise pregnant women about the risks if they or their baby contracts COVID-19.

Better engagement with GPs

Regular engagement with GPs in the community by those responsible for developing and implementing health policy would:

- ensure that policies effectively address issues experienced by GPs and other frontline health workers
- allow for adequate planning, increased safety and more efficient primary healthcare delivery
- increase public confidence and minimise uncertainty about the impact of events such as the COVID-19 pandemic
- ensure GPs are valued and able to adapt quickly to challenging situations, strengthening their capacity to provide optimal care
- improve the quality of information provided to the public (eg about accessing healthcare during the pandemic, what to do if they feel unwell or require testing).

The RACGP recommends:

- where possible, PHNs and/or state health bodies provide GPs with access to:
  - government modelling and local descriptive epidemiological data
  - clear, concise and accessible evidence-based information on clinical care for different population groups, especially those vulnerable and at higher risk
  - timely information regarding patient COVID-19 test results, including via My Health Record
  - information regarding patient admission or discharge from hospital or other services *(Recommendation 11)*
- evidence-based advice be provided on how to care for different population groups with varying needs during the pandemic *(Recommendation 12)*
- a nationally consistent set of criteria for testing infectious disease be developed to minimise confusion *(Recommendation 32)*
- an RACGP representative sit on the AHPPC *(Recommendation 33)*
- there be formal and permanent GP representation on state and territory health management committees *(Recommendation 34)*
- each jurisdiction establish a pandemic response plan that is exercised, reviewed and updated regularly with the involvement of GPs *(Recommendation 35)*
- state-based health response roundtables be established *(Recommendation 36)*
- involvement of GPs and other primary care practitioners in PHNs, hospital districts and other coordinating health and emergency response services be increased. The expertise of these practitioners will assist with planning for and responding to future pandemics and emergencies in general, such as bushfires *(Recommendation 37)*
- a national coordinated body be established to ensure consistent public messaging *(Recommendation 38)*.

3.12. Preventing the spread of misinformation

3.12.1. Overview of RACGP position

The COVID-19 pandemic has given to rise to the spread of harmful misinformation via social media platforms such as Facebook, Twitter and Instagram. In particular, advice regarding vaccinations from non-medical experts can jeopardise the health of people who read and accept this information as truth. The RACGP has welcomed news that popular social media platforms are acting to limit the impact of misleading information concerning the COVID-19 pandemic.

There have also been instances where a lack of restraint and critical and objective reflection in more traditional media has generated and circulated misinformation and invited reactions against necessary public health measures (eg unwarranted and over exuberant promotion of 'cures' and progress in vaccine development, demonising populations and inflaming grievances against state and territory governments).

The RACGP echoes calls from the Australian Medical Association[11] for increased public health education to be provided around the importance of vaccinations and their role in combating the spread of disease. Development of a vaccination is likely key to ending the COVID-19 pandemic. It is also critical that people are encouraged to get their influenza vaccination this year to ensure hospital beds do not become overcrowded with patients presenting with influenza and COVID-19 simultaneously.

We encourage the Australian Government to continue to respond swiftly to limit the distribution of misleading information, particularly around vaccinations, on all media platforms. An appropriate balance must be found between removing harmful information and ensuring people's right to freedom of speech is maintained.

The RACGP recommends:

- the Australian Government fund a public awareness campaign to educate Australians about the importance of immunisations, and heeding the advice of medical experts rather than celebrities who promote views contrary to scientific evidence *(Recommendation 13)*.

3.13. Impact of the COVID-19 pandemic on specific patient cohorts

3.13.1. Issue

There is a need to ensure that the most vulnerable people in our communities and those at higher risk are supported and cared for. The following section uses examples of a number of specific groups to demonstrate the impact the pandemic has had on the community, and how we need to carefully consider the needs of such populations in our pandemic response, specifically:

- Aboriginal and Torres Strait Islander people
- women's fertility
- people from CALD backgrounds, refugees and asylum seekers
- people in rural and remote areas.

3.13.2. Aboriginal and Torres Strait Islander people

The Australian Government should be commended for recognising early the risks of the pandemic in Aboriginal communities, and responding to calls to establish an Aboriginal and Torres Strait Islander Advisory Group. Established in early March and co-led by the National Aboriginal Community Controlled Health Organisation (NACCHO), the Advisory Group has implemented actions that may not have otherwise been achievable.[12]

Many RACGP members who work in mainstream general practice or other health services regularly provide healthcare to Aboriginal and Torres Strait Islander patients.

Measures to keep the virus out of remote communities have been ambitious and focussed on preventive action. To date, there have been no confirmed Aboriginal and Torres Strait Islander cases in remote or very remote locations.[13]

Member feedback and RACGP position

The Aboriginal Community Controlled Health Organisation (ACCHO) and Aboriginal Medical Service (AMS) sector has demonstrated its leadership, expertise and adaptability during this pandemic,[14] and the bushfire season that preceded it. The immediate and effective response from within the sector has occurred in spite of existing resource limitations.

While additional funding allocated to address COVID-19 is welcomed, it falls short of what is needed to ensure consistent delivery of high-quality healthcare in the context of COVID-19.[15]

The government's *Management Plan for Aboriginal and Torres Strait Islander populations*, which includes an operational plan, has only been partially funded, which puts added pressure on organisations and individual health practitioners to fill the gaps. This affects not only ACCHOs and AMSs, but also those GPs in mainstream and other health services that provide healthcare for Aboriginal and Torres Strait Islander patients.

There is often a risk of 'unintended consequences' where policies are implemented rapidly, particularly for population groups that may have unique or specific requirements.

Impact of the COVID-19 pandemic on Aboriginal and Torres Strait Islander health outcomes

The AHPPC has stated that 'Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic medical conditions…are, or are likely to be, at higher risk of serious illness if they are infected with COVID-19'.[16]

Anecdotally, one of the effects of this directive was for Aboriginal Health Workers who considered themselves at risk to stop working, which has flow-on effects for their patients.

There is currently no evidence to indicate that Aboriginal and Torres Strait Islander peoples with chronic conditions are at a higher risk of serious illness from COVID-19 than non-Indigenous people with similar chronic conditions and of the same age. Age and chronic conditions, rather than Indigeneity, are the risk factors, though this is further impacted by access to appropriate and culturally safe health services.

While there is a critical need to protect frontline staff, there is also a need to ensure that the community has access to appropriate healthcare. Aboriginal and Torres Strait Islander leaders should be involved in developing and implementing recommendations around the identification of populations with a higher risk of contracting COVID-19 and those vulnerable to serious COVID-19 illness.

As resources and focus are redirected to address COVID-19, there is potential for adverse health outcomes as a result of reduced availability of, access to and engagement with healthcare. There are risks, already evident in some cases, of

- patients not presenting to primary care for routine health checks and management of chronic disease
- reduced access to specialist medical services (both from the perspective of patients and GPs)
- extended wait times for elective care
- health workforce shortages within the fly-in-fly-out workforce
- Indigenous patients being denied access to specific services[17]
- Indigenous patients experiencing racism in health services[17]
- travelling to access specialist care.

In the context of Aboriginal and Torres Strait Islander health, this is likely to have a significant effect, given the relatively higher burden of chronic disease across the population. It is not yet clear how these delays and shortages will be managed.

More broadly, there are consequences that the RACGP is less qualified to speak on, but should be addressed by those with relevant expertise. The social and cultural impacts of the pandemic will be felt across all populations in different

ways, and these will have consequences for health and wellbeing. This is no different for Aboriginal and Torres Strait Islander communities, where the significance of not being able to attend funerals and time away from country may not yet be well understood.

Prevention and management of COVID-19

There has been a limited government response focussed on prevention and management of COVID-19 and funding for such activities.

NACCHO and the RACGP have identified an urgent need to provide practical advice to healthcare teams delivering prevention and management of COVID-19 to Aboriginal and Torres Strait Islander people in primary healthcare, based on best available evidence. Alongside researchers at the Australian National University, we aim to address this knowledge gap by delivering a range of clinical recommendations on the prevention and management of COVID-19.

It is also important to note the need for community-specific information. A number of communities have already developed resources to suit local environments, for example the Kimberley Coronavirus Animation.[18]

Members have noted that funding to support infrastructure development and education in remote Aboriginal communities has been invaluable. Furthermore, the government's biosecurity laws – though complicated – have provided protection for our most vulnerable communities.

MBS telehealth items

Telehealth provision to Aboriginal and Torres Strait Islander people needs to be culturally safe, well-resourced and supported.

The introduction of MBS item 92004 has generated considerable discussion. Primarily, concerns have been raised about how to conduct a high-quality and effective health assessment that is valued by the patient via telehealth.

In addition, without adequate quality controls and oversight, there is no way to guarantee the 92004 health assessment will be conducted in a culturally and clinically safe way that benefits the patient. Some consideration should be given to introducing processes which ensure payment only for health services and practices at which the patient is registered for the Practice Incentives Program Indigenous Health Incentive (PIP IHI) and has attended regularly for their healthcare.

Incomplete and confusing directives from the Department of Health about what is required to qualify for the rebate have also compounded the transition to the use of telehealth services. The RACGP and NACCHO are currently developing resources to support effective telehealth for Aboriginal and Torres Strait Islander people during the pandemic, including the 92004 health assessment (funded by the Department of Health).

Social determinants of health

The social determinants of health have been largely ignored in the response to the pandemic in the context of Aboriginal and Torres Strait Islander health, though the suspension of face-to-face 'mutual obligation' requirements, even if belated, was a welcome measure to protect communities.[19]

For some time, there have been calls for increased funding to improve remote housing conditions. The effects of COVID-19 further highlight the need to address this and other social issues, such as the over-representation of Aboriginal and Torres Strait Islander people in custody. NACCHO's recent calls for additional resourcing for remote housing, Aboriginal community-controlled health and social services[20] to better insulate communities from the effects of the virus have not been acted upon.

The health and social care sector is currently the largest employer of Aboriginal and Torres Strait Islander people.[21] Investment in building the resilience and capacity of the sector is not just about service provision. It is also about investing in the employment of Aboriginal and Torres Strait Islander people. This potential area for growth has also not been considered in the current response.

In the longer term, the social determinants of health, such as the adequacy of housing, community infrastructure and regional decision-making must be addressed to ensure community preparedness for future epidemics, pandemics and emergency events.

Lessons for future crises

Aboriginal and Torres Strait Health leadership will remain important to navigate the 'post-COVID-19' environment.

The pandemic highlights a need to explore what is required in ACCHOs and AMSs to provide effective primary healthcare during emergencies such as epidemics, pandemics and natural disasters. It will be opportune to conduct a needs analysis for resources to support the sector during future pandemics, epidemics and natural disasters.

The Australian Government's response to COVID-19 demonstrates it is able to act definitively, rapidly, collaboratively and follow evidence-based advice in the face of a serious health emergency. This sets an important precedent in how the government approaches other complex policy challenges in the future, particularly those relating to Aboriginal and Torres Strait Islander health.

The RACGP recommends:

- additional funding be provided to support Aboriginal and Torres Strait Islander people during the pandemic. There should be a particular focus on delivering culturally appropriate preventive health activities, and addressing social determinants of health to ensure community preparedness for future pandemics *(Recommendation 14)*.

3.13.3. Women's fertility services

Member feedback

Our members report that women's health has been significantly affected during the COVID-19 pandemic, leaving many women vulnerable to poor health outcomes.

Issues include:

- ceasing access to in vitro fertilisation for women when their fertility care is time-critical. This had devastating results and significantly affects pregnancy outcomes
- limited access to abortions due to these procedures being deemed as elective surgeries.

3.13.4. People from culturally and linguistically diverse (CALD) backgrounds, refugees and asylum seekers

Member feedback and RACGP position

Patients of CALD, refugee and asylum seeker background are experiencing reduced access to general practice and routine medical services as a result of the pandemic. There are specific barriers for this cohort that have arisen from the introduction of COVID-19 MBS telehealth services.

These include:

- limited English language skills
- reduced access to technology including phones and internet connectivity
- a lack of video consultation platforms currently available that enable the use of interpreters
- the unavailability of the Translating and Interpreting Service (TIS National) for video consultations. Video consultations offer a layer of 'visual examination' and non-verbal information, superior to telephone consultations, which is particularly useful where language barriers exist

- reduced face-to-face and outreach appointments
- an increase in mental health symptoms, compounded by past experiences of trauma. GPs have reported that the pandemic has had a devastating impact on patients who have been living in uncertainty for prolonged periods. Many are from countries severely affected by COVID-19, particularly Iran.

Additionally, this group has been significantly impacted by a loss of casual work as a consequence of the pandemic. GPs have also reported a lack of multilingual options when using the COVIDSafe application and online symptom checkers.

The following recommendations are aimed at improving access to healthcare and health outcomes for asylum seekers, refugees and people from CALD backgrounds.

The RACGP recommends:

- greater financial assistance be provided for people without work rights and those unable to access support through the Status Resolution Support Services program. *(Recommendation 15)*
- targeted education be provided in different languages, tailored to varying health literacy levels, around COVID-19 testing, treatment, public health management strategies, the implications of a positive test and the need for self-isolation. *(Recommendation 16)*.

3.13.5. People in rural and remote areas

Member feedback

Specific issues raised by members in relation to rural and remote areas include:

- confusion around biosecurity laws and their impact for people in remote communities
- limited access to healthcare, with many services cancelled and the workloads of GPs increasing as a result
- staff shortages, with limited government assistance provided to address these
- the cessation of locum placements and some regular fly-in fly-out clinicians
- difficulties accessing fever clinics and respiratory clinics.

3.14. Matters for further consideration, including social consequences of the pandemic

3.14.1. Issue

Matters for further consideration have been identified.

3.14.2. Member feedback and RACGP position

As the pandemic continues to progress, consideration should be given to the following issues which could impact on the provision of care to patients by GPs:

- recurring incidences of community transmission
- broadening of indications for testing to include any patient with a wide array of respiratory symptoms
- advice that to see/examine/swab a patient with suspected COVID-19 requires the GP to be in full PPE (which is lacking in many areas) and the consultation room to be an isolation room which will need to be fully cleaned afterwards
- limited supply of full PPE available to GPs, and the lack of suitable isolation rooms in some practices
- the approaching influx of winter respiratory illness
- the impact of the pandemic on the mental health of the population as a result of strict lockdown measures aimed at limiting the spread of the virus

- increased cases of domestic violence and poverty.

The RACGP recommends:

- increased funding and resources be provided to support GPs to respond to a predictable increase in mental health issues, domestic violence and poverty as a result of the pandemic *(Recommendation 39)*.

3.15. Other comments

3.15.1. Racism toward doctors of Asian appearance

The RACGP has strongly condemned racist attacks against doctors of Asian appearance due to fears regarding the pandemic's origins. These attacks are completely unacceptable and unwarranted. Racism has no place in Australian society, and steps must be taken to ensure doctors are protected and supported.

3.15.2. Potentially premature easing of restrictions

Members have expressed concern that restrictions on movement during the COVID-19 pandemic may be lifted prematurely, potentially increasing the risk of infection in the community. While we recognise that the enforcement of restrictions is exercised at a state and territory level, we encourage the Australian Government to carefully consider and exert its influence where necessary to ensure the timing of any changes does not increase risks to health.

3.16. Engagement with the RACGP

The RACGP wishes to acknowledge and thank the Commonwealth Department of Health for its rapid and ongoing engagement with health stakeholders during the pandemic. Departmental staff have been responsive to the RACGP's enquiries – particularly regarding Medicare item numbers – which has greatly assisted us to disseminate timely, accurate information to our members.

The RACGP has participated in ongoing and regular discussions with the Department of Health and other GP peak bodies, this has enabled the RACGP to raise important issues of relevance to GPs, and contribute to policy discussions on the COVID-19 health sector response.

We also wish to note the value of having a senior GP – Professor Michael Kidd AM – in the role of Deputy Chief Medical Officer.

The Department's commitment to engaging with the general practice sector during this time of great uncertainty is valued and appreciated by our members. The RACGP welcomes future opportunities to continue driving the health policy agenda in Australia by working closely with government at all levels.

4. Conclusion

GPs and general practice teams have been working tirelessly to continue caring for their patients during this unprecedented global pandemic. As frontline health staff, they must be supported to keep doing so.

The RACGP hopes the lessons from the COVID-19 response will highlight the longstanding need for increased funding to be provided by all levels of government to support general practice, which will enable ongoing patient access to high-quality, affordable care. This pandemic has highlighted the critical role that GPs play in Australia's healthcare system. This must not be jeopardised due to inadequate funding and a lack of coordination.

The primary healthcare response to this pandemic is far from over. It may continue for several years, as health services and GPs manage the mental health and other effects resulting from this period. There is currently limited discussion

about supports available when the immediacy of the crisis has passed. The RACGP therefore cautions against a return to 'business as usual' in the wake of COVID-19.

The RACGP looks forward to contributing to further discussions around the Australian Government's response to the COVID-19 pandemic.

Should you have any questions or comments regarding the RACGP's submission, please contact Ms Michelle Gonsalvez, National Manager – Policy and Advocacy, on (03) 8699 0490 or at michelle.gonsalvez@racgp.org.au

5. References

[1] Department of Health. Daily number of reported COVID-19 cases in Australia. Canberra: DoH, 2020. Available at https://www.health.gov.au/resources/daily-number-of-reported-covid-19-cases-in-australia [Accessed 20 May 2020].
[2] Heal C, Roberts G. General practice research priority setting in Australia: Informing a research agenda to deliver best patient care. Aust J Gen Pract 2019;48(11):789–95. doi: 10.31128/AJGP-05-19-4928
[3] McArthur G. Health system crisis looms. Sunday Herald Sun. 24 May 2020: 3.
[4] Cunningham M. Fears seriously ill people going unchecked as cancer referrals plummet. Sydney: The Sydney Morning Herald, 26 April 2020. Available at https://www.smh.com.au/national/fears-seriously-ill-people-going-unchecked-as-cancer-referrals-plummet-20200426-p54n95.html [Accessed 20 May 2020].
[5] The Royal Australian College of General Practitioners. Vision for general practice and a sustainable healthcare system. East Melbourne, Vic: RACGP, 2019.
[6] Clun R. Health Minister wants telehealth to continue after COVID-19 pandemic. Sydney: The Sydney Morning Herald, 7 May 2020. Available at https://www.smh.com.au/national/health-minister-wants-telehealth-to-continue-after-covid-19-pandemic-20200506-p54qfj.html [Accessed 23 May 2020].
[7] Consumers Health Forum of Australia. Staying connected – so doctor and consumer know best. Deakin, ACT: CHF, 28 April 2020. Available at https://chf.org.au/media-releases/staying-connected-so-doctor-and-consumer-know-best [Accessed 23 May 2020].
[8] General Practice Registrars Australia. Impacts of COVID-19 on GP trainee employment survey – summary report. Melbourne: GPRA, 21 April 2020.
[9] Australian Institute of Health and Welfare. Medical practitioners workforce 2015. Canberra: AIHW, 2016. Available at https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015/contents/how-many-medical-practitioners-are-there [Accessed 20 May 2020].
[10] The Hon Greg Hunt MP, Minister for Health. World first rapid COVID-19 testing to protect Aboriginal and Torres Strait Islander communities. Canberra: Department of Health, 16 April 2020. Available at https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/world-first-rapid-covid-19-testing-to-protect-aboriginal-and-torres-strait-islander-communities [Accessed 23 May 2020].
[11] Koslowski M. 'Act now': AMA urges health education to combat 'growing' anti-vaxxer movement. Sydney: The Sydney Morning Herald, 25 May 2020. Available at https://www.smh.com.au/national/act-now-ama-urges-health-education-to-combat-growing-anti-vaxxer-movement-20200525-p54w7b.html [Accessed 27 May 2020].
[12] Ward J. Bullet proofing Aboriginal and Torres Strait Islander communities from COVID-19. Cygnet, Tas: Croakey, 22 April 2020. Available at https://croakey.org/bullet-proofing-aboriginal-and-torres-strait-islander-communities-from-covid-19/?fbclid=IwAR3KjXkVWuhpKe3TnbN9XD84Gb61Rvqv6G4jstQV-qNHanFpMfzTm8P2sCM [Accessed 20 May 2020].
[13] COVID-19 National Incident Room Surveillance Team. COVID-19, Australia: Epidemiology Report 16: Reporting week ending 23:59 AEST 17 May 2020. Commun Dis Intell 2020;44. doi: 10.33321/cdi.2020.44.45.
[14] McQuire A. Aboriginal community health's success with Covid-19. Carlton, Vic: The Saturday Paper, 25 April 2020. Available at https://www.thesaturdaypaper.com.au/news/health/2020/04/25/aboriginal-community-healths-success-with-covid-19/15877368009740 [Accessed 20 May 2020].
[15] Wilson G. Our Indigenous community is being left on the bench. Sydney: The Australian Financial Review, 19 April 2020. Available at https://www.afr.com/policy/economy/our-indigenous-community-is-being-left-on-the-bench-20200419-p54l4p [Accessed 20 May 2020].
[16] Department of Health. Australian Health Protection Principal Committee (AHPPC) Advice to National Cabinet on 30 March 2020. Canberra: DoH, 30 March 2020. Available at https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-to-national-cabinet-on-30-march-2020 [Accessed 20 May 2020].

[17] Australian Indigenous Doctors' Association. Indigenous doctors warn that racism will cost lives. Parkes, ACT: AIDA, 26 March 2020. Available at https://www.aida.org.au/wp-content/uploads/2020/03/Indigenous-Doctors-warn-that-racism-will-cost-lives-MEDIA-RELEASE.pdf [Accessed 20 May 2020].
[18] Trench-Thiedeman B, et al. Kimberley coronavirus animation. Broome, WA: Nirrumbuk Environmental Health and Services and Kimberley Aboriginal Medical Services, 2020. Available at https://vimeo.com/407920895?ref=tw-share [Accessed 20 May 2020].
[19] Allam L. Aboriginal medical service demands urgent change to work-for-dole rules to reduce coronavirus risk. Sydney: The Guardian, 18 March 2020. Available at https://www.theguardian.com/australia-news/2020/mar/18/aboriginal-medical-service-demands-urgent-change-to-work-for-dole-rules-to-reduce-coronavirus-risk [Accessed 20 May 2020].
[20] Mackinolty C. Urgent calls for more resources to protect Aboriginal and Torres Strait Islander communities from COVID-19. Cygnet, Tas: Croakey, 13 March 2020. Available at https://croakey.org/urgent-calls-for-more-resources-to-protect-aboriginal-and-torres-strait-islander-communities-from-covid-19/ [Accessed 20 May 2020].
[21] Australian Bureau of Statistics. 2076.0 – Census of Population and Housing: Characteristics of Aboriginal and Torres Strait Islander Australians, 2016. Canberra: ABS, 2018. Available at https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2076.0Main%20Features512016?opendocument&tabname=Summary&prodno=2076.0&issue=2016&num=&view= [Accessed 20 May 2020].

RACGP
Royal Australian College *of* General Practitioners

Appendix A: Proposed short-term solutions to improve MBS telehealth services

1. Additional telehealth items for general practice services

The RACGP welcomes the range of COVID-19 Medicare Benefits Schedule (MBS) telehealth items available for use by GPs, with the majority of non-procedural attendance items covered. However, there is a need for equivalent telehealth items to be created for:

- health assessments *(equivalent to existing items 701, 703, 705 and 707)*, noting that while a comprehensive and appropriate assessment may not be fully realisable via telehealth, delays in assessment affect timely identification, planning and management:
    - Additional health assessment items are needed, particularly for people aged over 75 and/or residents of aged care facilities, given the tragic impact of COVID-19 on elderly people and in aged care facilities.
    - If the intent of telehealth is to support access to GPs for vulnerable people, providing the capacity for a GP to undertake a health assessment for someone over 75 and/or residing in an aged care facility via telehealth fits within this framework.
    - Without the items, people who are vulnerable are forced to attend a practice for a face-to-face consultation for this service.
    - Older people, who are among the most susceptible to COVID-19 complications, will likely miss out on their annual health assessment. These assessments provide an invaluable opportunity for GPs to consider the needs of their patients and evaluate current care.
    - The government has supported patient access to geriatrician health assessments via telehealth.
    - Telehealth items equivalent to MBS item 715 (Aboriginal and Torres Strait Islander peoples' health assessment) were introduced.

- after-hours care provided during sociable hours *(equivalent to existing items 5020, 5040 and 5060)*:
    - Members have reported a loss of income as a result of this omission.
    - Providers have been advised the general telehealth item numbers can be used to provide after-hours care, however the rebates are far lower and do not recognise the added impost of providing care on weekends or during the evening.
    - There are telehealth items available for the provision of urgent after-hours care during unsociable hours. Items 92210 (videoconferencing) and 92216 (phone) are equivalent to existing item 599.

- professional attendances at a residential aged care facility *(equivalent to existing items 90020, 90035, 90043 and 90051)*:
    - Providers have been advised the general telehealth item numbers can be used to provide care to patients in residential aged care facilities.
    - However, these items do not qualify for the Aged Care Access Incentive through the Practice Incentives Program, which means GPs could lose access to the incentive payment this year as their services are not recorded.
    - This also affects the ability to report on and analyse service use in aged care facilities, which is of interest to the current Royal Commission into Aged Care Quality and Safety.

- home and residential medication reviews *(equivalent to existing items 900 and 903)*:
    - It was recently announced that 6CPA medicine review program services can now be delivered by telehealth to eligible patients, and follow-up consultations by pharmacists will also be remunerated.
    - The same provisions have not been made for GPs to provide medication reviews.